Valuing the Social Mission Activities of Blue Cross Blue Shield of Michigan

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January 2008 | Washington, DC

Avalere

A Note on the Genesis of This Report

This report is a product of Avalere Health, LLC, an independent health policy research and advisory services firm based in Washington, DC. Blue Cross Blue Shield of Michigan commissioned Avalere to prepare the report in December 2007. Avalere Health's 100-plus professionals serve a range of commercial, non-profit and governmental customers with interests in improving the health system.

The lead author is Bob Atlas, Senior Vice President of Avalere Health since November 2005. Mr. Atlas is a member of Avalere's executive leadership team, with responsibility for all of the company's advisory services. He has three decades of experience in strategy, policy analysis, program development, and performance improvement for health care providers, payers, and policymakers.

In late 2005 and early 2006, Mr. Atlas was the lead analyst in an initial study of Blue Cross Blue Shield of Michigan's social mission spending. That study was issued by the Altarum Institute of Ann Arbor, Michigan, which Mr. Atlas was serving as a consultant. This report updates that earlier study.

Earlier in 2005, Mr. Atlas led a study of social mission spending of the Blue Cross and Blue Shield plans in Pennsylvania, commissioned by the Pennsylvania state legislature. That report was produced by The Lewin Group of Falls Church, Virginia, to which Mr. Atlas was consulting at the time and where he served as President until January 2004. The report done for Pennsylvania underpins the analysis contained in this document.

Executive Summary

Blue Cross Blue Shield of Michigan (BCBSM) is the only health plan in Michigan regulated as a nonprofit health care corporation under Public Act 350. PA 350 exempts BCBSM from paying state and local taxes, but also requires the plan to operate in a way that will "secure for all the people of this state…the opportunity for access to health care services at a fair and reasonable price."

To meet these requirements, BCBSM performs various functions that benefit the community, its so-called "social mission" functions. BCBSM commissioned Avalere Health to measure the value of these social mission functions in dollar terms. Findings of our analysis and assessment of BCBSM's fulfillment of its social mission obligations are summarized below.

The Unique Requirements Placed on BCBSM

Under PA 350, BCBSM faces two significant demands that do not apply to any other health insurer in the state. The first stipulation is that BCBSM must "guarantee issue and renew" its three individual health insurance products to all Michigan residents, and BCBSM cannot decline to renew a policy once it has been issued. BCBSM, however, is the only insurer in the state that must guarantee issue individual products year-round and, as such, BCBSM operates as the **state's insurer of last resort.**

The second provision under PA 350 that is unique to BCBSM, is that the Insurance Commissioner is permitted to mandate that BCBSM charge subscribers an amount in addition to what their premium would otherwise be in order to **subsidize two of the individual products**. This extra charge is based on a percentage of premium.

Valuing BCBSM's Social Mission Spending

No rules exist for valuing nonprofit insurers' social mission activities. The best available framework emerged in a study done in 2005 for the Pennsylvania legislature to assess the social mission activities of that state's four Blue Cross and Blue Shield plans.[1] Avalere Health further validated the use of this framework in interviews with two leading experts on nonprofit health care organizations' community benefits.

The main areas of BCBSM's social mission funding, under the Pennsylvania framework, are defined and measured as follows (dollar values are for 2007):

- **Direct Charitable Giving - $5.0 million.** BCBSM's direct charitable giving included funding for free care clinics and community health initiatives and the value of donations through corporate/volunteer giving programs.
- **Knowledge Dissemination and Research - $17.2 million.** These activities included BCBSM's support for the Michigan Quality Improvement Consortium, Cardiovascular Consortium, the Michigan Surgical Quality Improvement Program and more. BCBSM's outlays for health care education, as well as its Hospital Pay-for-Performance program, are also counted in this category.

[1] The Pennsylvania House of Representatives tasked the Legislative Budget and Finance Committee to "examine options and alternatives available to the Commonwealth with respect to the regulation, oversight and disposition of reserves and surpluses of health insurers."

- **Participation in Public Programs - $15.5 million.** This is the amount of premium shortfalls BCBSM incurs in MIChild, the state children's health insurance program. It represents a definitive commitment by BCBSM to subsidize MIChild.
- **Safety Net Coverage - *At least* $353 million.** BCBSM's losses on certain products, Medicare Supplement and Group Conversion subsidies, and outlays related to being Michigan's insurer of last resort, total $275.5 million or more. In addition, BCBSM's payments to Michigan hospitals toward their costs of uncompensated care are valued for social mission measurement purposes at $77.5 million.

In sum, using our conservative framework, we estimate that BCBSM's total social mission spending in 2007 was **at least $391 million**. The true amount is likely higher given the hard-to-quantify value of BCBSM's insurer of last resort status and associated business costs.

Benchmarking BCBSM's Overall Social Mission Spending

Even though there is no specific level of spending that BCBSM is required to deliver, and against which its level of social mission spending can be evaluated, we identified two benchmarks against which to judge BCBSM's fulfillment of its social mission obligation.

We compared the BCBSM spending to that of the largest Blues plan in Pennsylvania, Highmark. Highmark's social mission obligation is spelled out by that state's Community Health Reinvestment Agreement and a statutory mandate pertaining to insurer of last resort. On a per capita basis, BCBSM spends 37 percent more than Highmark.

We also compared BCBSM's social mission spending to the state and local tax exemption granted by PA 350. By this measure, Michigan residents actually receive significant extra benefits as a result of BCBSM's unique status under Michigan law. BCBSM estimates that the tax exemption saved the company $80 million in 2007. Our estimate of BCBSM's social mission spending, $391 million (minimum) is 4.88 times this value.

Conclusion

We believe BCBSM is meeting its social mission obligations in terms of the level of spending. Analysis of 2007 social mission outlays shows that BCBSM is, in fact, surpassing the amount of social mission spending expected under PA 350.

BCBSM Social Spending

As a nonprofit entity, Blue Cross Blue Shield of Michigan (BCBSM) has an obligation to perform certain charitable and benevolent activities. BCBSM also holds a distinct status under Michigan statutes in that it is the only health plan in the state regulated as a nonprofit health care corporation under Public Act 350. PA 350 exempts BCBSM from paying state and local taxes, but also confers upon the plan unique requirements to ensure that BCBSM operates in a way that will "secure for all the people of this state…the opportunity for access to health care services at a fair and reasonable price."[2]

Public Act 350 sets forth the social mission obligations of nonprofit health care corporations as follows:

> *It is the purpose and intent of this act, and the policy of the Legislature, to promote an appropriate distribution of health care services for all residents of this state, to promote the progress of the science and art of health care in this state, and to assure for non-group and group subscribers, reasonable access to and reasonable cost and quality of health care services, in recognition that the health care financing system is an essential part of the general health, safety, and welfare of the people of this state.*

BCBSM has acknowledged the requirements of PA 350 in this manner:

> *While making us free of state taxes, PA 350 also confers upon us the special responsibility of being Michigan's health care safety net. … While for-profit companies generate profits for their stockholders, we self-limit our margins to serve the residents of Michigan. The premiums we collect not only pay for the very highest quality health care, but they help us underwrite health insurance for uninsured children; subsidize Medicare Supplemental coverage for seniors; fund Michigan-based medical research; commit resources to address select public health issues; and, when we perform well financially, moderate future premiums to provide even greater access to health care for the people of Michigan*.[3]

To meet the requirements demanded by PA 350, BCBSM performs various social mission functions. The aim of this document is to quantify the level of BCBSM's social mission outlays. To do this, we first determined which BCBSM community benefit activities have a social mission component to them, and identified the amount that BCBSM spends annually on these activities. We then analyzed that level of spending in a number of different ways to assess BCBSM's fulfillment of its social mission obligations.

Findings are outlined in the following sections:

- **Identifying the Unique Requirements Placed on BCBSM.** As a nonprofit entity, BCBSM has an obligation to perform certain charitable and benevolent activities. However, as a health care corporation, PA 350 places other requirements on BCBSM that do not apply to any other health insurer in the state. Understanding these requirements is a critical precursor to gauging which activities should, or should not, count toward fulfilling a social mission obligation.

[2] PA 350 - The Nonprofit Health Care Corporation Reform Act (1980)
[3] Blue Cross Blue Shield of Michigan 2004 Annual Report

- **Determining BCBSM's Social Mission Spending.** This step entailed determining the activities performed by BCBSM in 2007 that should be considered as fitting the social mission. Our determination is based on commonly accepted frameworks, as well as our analysis of PA 350.

- **Benchmarking BCBSM's Overall Social Mission Spending.** There is no specific level of spending required of BCBSM, against which its level of social mission spending can be evaluated. However, we did identify proxies by which we could compare the level of spending to assess if BCBSM meets it social mission obligation.

Identifying the Unique Requirements Placed on BCBSM

There are two important requirements placed on BCBSM under PA 350 that do not apply to other health insurers in Michigan and which impact social mission spending. This section highlights those requirements since they are relevant to BCBSM fulfilling its obligation to provide access to health care services at a fair and reasonable price. Other requirements placed on BCBSM through PA 350 are not included because they are not relevant for this question. For example, PA 350 sets forth the specific composition of the plan's Board of Directors. While such a requirement is unique to BCBSM, it does not directly impact BCBSM's level of social mission spending and, therefore, has been excluded from this analysis.

Insurer of Last Resort

BCBSM provides individual coverage through three plans: non-group, group conversion and Medicare supplemental.

- The individual **non-group plan** provides coverage for individuals ineligible for Medicare or group coverage.
- The individual **group conversion plan** offers coverage to individuals who have lost their BCBSM group coverage and are not eligible for Medicare.
- Individual **Medicare supplemental** coverage is sold to individuals who are eligible for Medicare but not covered by a group plan.

Under PA 350, BCBSM is required to "guarantee issue and renew" these individual health insurance products to all Michigan residents.[4] Health plans offering insurance products on a guaranteed issue basis cannot turn applicants down based on health or risk status. Additionally, BCBSM cannot decline to renew a policy once it has been issued. HMOs operating in Michigan are required to guarantee issue to a limited number of applicants during one annual 30-day open enrollment period.[5] Commercial insurers other than HMOs are not subject to any guarantee issue requirements. BCBSM is the only insurer in the state that must guarantee issue individual products year-round and, as such, BCBSM operates as the state's insurer of last resort.

[4] BCBSM is also required to issue and renew insurance contracts with other customer segments as well, including the small group market. However, that requirement is not unique to BCBSM.

[5] Act 218, Chapter 35 Health Maintenance Organizations, p. 11. Requirement only applied to HMOs operating in the state for longer than 24 months.

Offering individual policies can be risky for a heath insurer, in that plans participating in this market may be more likely to experience adverse selection. Therefore, it is important for an insurer to have the ability to price the products in a way that accounts for that risk. Within the individual market, BCBSM is afforded very little premium rating flexibility, as opposed to the commercial carriers who have virtually no constraints on their rating methods. Rates for all BCBSM individual plans must be approved by the Office of Financial and Insurance Services (OFIS) before they can be used.[6] These rate submissions are subject to public hearings as well, which may result in a substantial delay in their implementation. In contrast, HMOs in Michigan (including the HMO owned by BCBSM) file their rates with OFIS prior to use, but HMOs are permitted to go ahead and use those rates as long as OFIS does not respond within 60 days.[7] Moreover, commercial insurers in Michigan do not have to seek rate approval at all; they are subject only to file-and-use regulations.

Within the rate-making process, BCBSM is subject to community rating requirements for most individual products. This means that BCBSM is prohibited from full medical underwriting and, with limited exceptions, BCBSM is also prohibited from age rating its individual plans.[8]

The requirement to continuously guarantee issue individual products, combined with the inability to rate the products competitively, is unique to BCBSM. This factor plays a large role in our assessing which activities pursued by BCBSM should count as social mission.

Product Subsidization Requirements

Under PA 350, the Insurance Commissioner may request, and in fact does consistently require, that BCBSM charge subscribers an amount in addition to what their premium would otherwise be in order to subsidize two of the individual products. This extra charge is based on a percentage of premium. The requirement to charge certain subscribers an amount above what their premium would otherwise be is unique to BCBSM, and is not required of other insurers in Michigan. Even though the costs are ultimately passed on to customers, we count this as part of social mission spending in much the same way that for-profit companies factor the costs of the taxes they pay to governmental entities into their premiums.

The products requiring cross-subsidization are:

- **Medicare Supplement Plans**. BCBSM adds a 1% charge to all groups to subsidize the cost of offering individual Medicare Supplement coverage. Groups not offering retiree coverage are assessed an additional 1% fee, for a total 2% above normal premium costs. Individual non-group subscribers are not exempt from this requirement, and are also assessed an extra 1% of premium to subsidize the Medicare Supplement product.

[6] PA 350 grants the Michigan Office of Financial and Insurance Services (OFIS) regulatory authority over BCBSM. The OFIS must pre-approve rates or rating formulas for all business that BCBSM underwrites. This includes coverage purchased by individuals and many of the coverage plans purchased by groups for their employers or members.

[7] Act 218, Chapter 35 Health Maintenance Organizations

[8] Full medical underwriting includes:

- declining coverage for older and sicker individuals,
- declining coverage for specific conditions or rating up premiums for specific conditions, and/or
- increasing rates at renewal when enrollees' health conditions deteriorate.

For example, Group A is fully insured by BCBSM and has annual premium costs of $1,000,000. Group A does not offer retiree coverage. As a result of this requirement, Group A would be assessed an additional charge of $20,000 ($1,000,000 x .02) in order to help subsidize BCBSM's cost of providing Medicare Supplement coverage to state residents.

- **Group Conversion Plans.** The group conversion plan is partially funded by a subsidy that BCBSM charges to the groups that previously covered these individuals. The amount of the subsidy varies by group size. On average, the subsidy is approximately 0.5% of a group's medical premium, which averages 0.4% on total premium. This fee is mandatory, and is in addition to the 1% or 2% subsidy required for the Medicare Supplemental plans. Individual subscribers are not required to pay any additional amount to subsidize group conversion plans.

  For example, in addition to the $20,000 that Group A must pay to subsidize the cost of offering Medicare supplemental plans, Group A is also assessed an additional $4,000 ($1,000,000 x .004) to subsidize the cost of BCBSM providing group conversion policies to qualified subscribers. Therefore, Group A is charged an additional $24,000 total.

There is no requirement to cross-subsidize the non-group individual plan offered by BCBSM. Additionally, subscribers to other products, including the group conversion, Medicare Supplement and Medicare Advantage plans, are not required to pay any subsidies.

Determining BCBSM's Current Social Mission Spending

There is no universally accepted definition of activities that count toward social mission spending and how those activities should be quantified. In three states, health plans are required to report social mission expenditures, but the guidelines and requirements for spending are not comprehensive enough to consider as a model. For example, in Massachusetts, HMOs must report community benefit activities under a non-regulatory set of voluntary principles promulgated by the attorney general.[9]

Minnesota law requires all licensed health plans to report to the Commissioner of Health detailing how they will collaborate with community health organizations to achieve public health goals.[10] Health plans are required to submit a plan every four years with details on public health activities. The state gives a framework for a health plan to use when drafting its submission, as well as recommendations on issues on which plans should focus. However, Minnesota does not mandate dollar amounts that plans must dedicate toward fulfilling public health goals.

The most advanced state in terms of providing both a high-level framework for social mission activities and a general guideline for how much BCBS plans should spend on social mission activities is Pennsylvania, which has in place an Agreement on Community Health Reinvestment. Executed in early 2005 by the Deputy Insurance Commissioner and the heads of the state's four Blue plans, this document sets forth a program by which the Blues,

[9] Tom Reilly, Attorney General, Commonwealth of Massachusetts, "The Attorney General's Community Benefit Guidelines for Health Maintenance Organizations," January 2002. Applicable to all HMOs licensed under MA General Laws, Ch.176G, S 1.
[10] Minnesota State Statute 62Q.075 Local public accountability and collaboration plan.

for the years 2005-2010, pledged somewhat more than one percent of their premium revenues to community benefits. Sixty percent of the funding is earmarked for a program that provides health insurance coverage to low-income adults not qualifying for Medicare or Medicaid coverage. The remainder is to go to other community benefit endeavors chosen by the Blues and approved by the Insurance Commissioner. However, even the Pennsylvania agreement does little to define which specific endeavors, beyond providing funding for insurance coverage, are to be considered as having a social mission component.

Lacking formal rules set in place by any regulatory entity, we relied upon a publicly recognized framework developed by The Lewin Group (whose engagement was led by the lead author of this report) to assess the social mission activities of the Blue Cross and Blue Shield plans in Pennsylvania ("Pennsylvania framework").[11] At the time that framework was developed, there were no uniform ways available to catalogue social mission activities. A second framework, released in November 2005 by the Alliance for Advancing Non-Profit HealthCare,[12] enables non-profit health plans "to assess and improve their practices in planning, implementing, assessing and reporting on their community benefits."[13]

While we used both sets of guidelines to assess BCBSM social mission activities, for the remainder of this paper our analysis will focus on how BCBSM's level of social mission spending aligns with the Pennsylvania framework. That framework seemed suitable primarily because it is conservative in its classification of what counts as social mission spending, and has stipulations for how various activities could be quantified. We have further validated the framework by interviewing two noted experts on social mission spending by non-profit insurers: Bruce McPherson, Executive Director of the Alliance for Advancing Non-Profit HealthCare, and Mark Schlesinger, professor of health policy at Yale University, who has published extensively on the topic.[14] See Exhibit 1 on page 10 for more detail on the Pennsylvania framework.

BCBSM's social mission funding is described below in accordance with the major categories of the framework.[15]

Direct Charitable Giving - $5.0 million. Direct charitable giving may include cash donations to not-for-profit organizations that help fill unmet health needs in the plan's services area, plus the value of employees' company-paid time off to support similar causes. BCBSM's direct charitable giving in 2007 amounted to $5.0 million, which included funding for free care clinics and community health initiatives, as well as the value of donations through corporate/volunteer giving programs.

Knowledge Dissemination and Research - $17.2 million. Knowledge dissemination and research includes health education and health promotion activities that are directed at the community at large, as opposed to just BCBSM subscribers. In 2007, BCBSM expended

[11] The Pennsylvania House of Representatives tasked the Pennsylvania Legislative Budget and Finance Committee to "examine options and alternatives available to the Commonwealth with respect to the regulation, oversight and disposition of reserves and surpluses of health insurers." This committee engaged the services of The Lewin Group to complete this study.
[12] The authors of the Pennsylvania framework benefited from seeing a draft of the Alliance's guidelines.
[13] Accessible at http://www.nonprofithealthcare.org/documentView.asp?docid=151&sid=
[14] See, for example, Mark Schlesinger and Bradford Gray, "How Nonprofits Matter in American Medicine, and What to Do About It," Health Affairs – Web Exclusive, June 20, 2006.
[15] Dollar values were supplied by BCBSM and not independently audited by Avalere Health. Avalere's charge was to validate that spending classified as social mission outlays does indeed meet the social mission definition.

$17.2 million on knowledge dissemination activities. These activities included BCBSM's participation in, and support for, programs such as the Michigan Quality Improvement Consortium, Cardiovascular Consortium, MI Thoracic and Cardiovascular Surgeons Quality Improvement Collaborative, and the Michigan Surgical Quality Improvement Program. BCBSM's expenditures for health care education, as well as its Hospital Pay-for-Performance program, also accounted for the knowledge dissemination funds.

Exhibit 1: The Updated Pennsylvania Framework[16]

Category	Community Benefit Practices	Stipulations
Direct Charitable Giving	• Cash donations to not-for-profit organizations that help fill unmet health needs in the heath plan's service area • Value of employees' company paid time offered in support of the same causes	Contributions made when the plan's purpose is mainly promotional are better classified as marketing costs
Knowledge Dissemination and Research	• Health education or health promotion activities • Conduct or sponsorship of clinical research or health services research	Education should be directed to the community at large, not just members Research outputs should be broadly available, not treated as proprietary
Participation in Public Programs	Contracting with public payer entities to enroll their beneficiaries • Medicaid • S-CHIP • Medicare • Special state/local coverage programs	Participation should be broad and long-term, maintained consistently across profitable and unprofitable sub-groups, territories, and spans of time irrespective of fluctuations in payment; valuation should consider uncovered costs only
Safety Net Health Coverage	• Offering of coverage to individuals other insurers will not accept, or price equitably, due to health history (open enrollment without full medical underwriting) • Subsidized premiums for individual and small-group coverage • Contributions to charity care pools • Subsidization of participating hospitals' charity care outlays	Any dollar valuation of community benefit should equal direct costs not covered by any premiums received, not forgone profit Mandatory charity care contributions may be counted if it is customary to do so according to community standards Payments to hospitals for charity care must be explicitly identifiable

[16] The framework is based in part off of the following source: Mark Schlesinger, Bradford Gray, et al, "A Broader Vision for Managed Care, Part 2: A Typology of Community Benefits," Health Affairs (17:5) September/October 1998.

Participation in Public Programs - $15.5 million. Public program participation may include providing coverage and/or administrative services in Medicaid, S-CHIP, Medicare, and other special state or local coverage programs. It may also include plans' expenditures related to contracting with public payer entities to enroll their beneficiaries. BCBSM's participation in the MIChild (S-CHIP) program falls under this category. The total BCBSM expenditure under the participation in public programs category in 2007 was $15.5 million, which is the amount of premium shortfalls that BCBSM incurs in MIChild. This represents a definitive commitment by BCBSM to subsidize MIChild by underpricing the product.

Safety Net Coverage - At least $353 million. The safety net coverage category includes community benefit practices such as: offering coverage to individuals that other insurers will neither accept nor price equitably due to health history; subsidizing premiums for individual and small-group coverage; and contributing to charity care pools and/or directly subsidizing hospitals' costs of charity care. BCBSM's losses on certain products, Medicare Supplement and Group Conversion subsidies, and expenditures related to being the state's insurer of last resort all fall under this category. Also in this category is money given to Michigan hospitals to cover a portion of their uncompensated care.

Direct losses BCBSM incurs through offering individual or small-group products should count as social mission spending since BCBSM is required to offer the products but is limited in its ability to set premiums high enough to cover the costs. In 2007, the direct losses associated with these products totaled $133.8 million,[17] all of which were incurred in the individual product segment. There were no losses in 2007 in the small-group market.

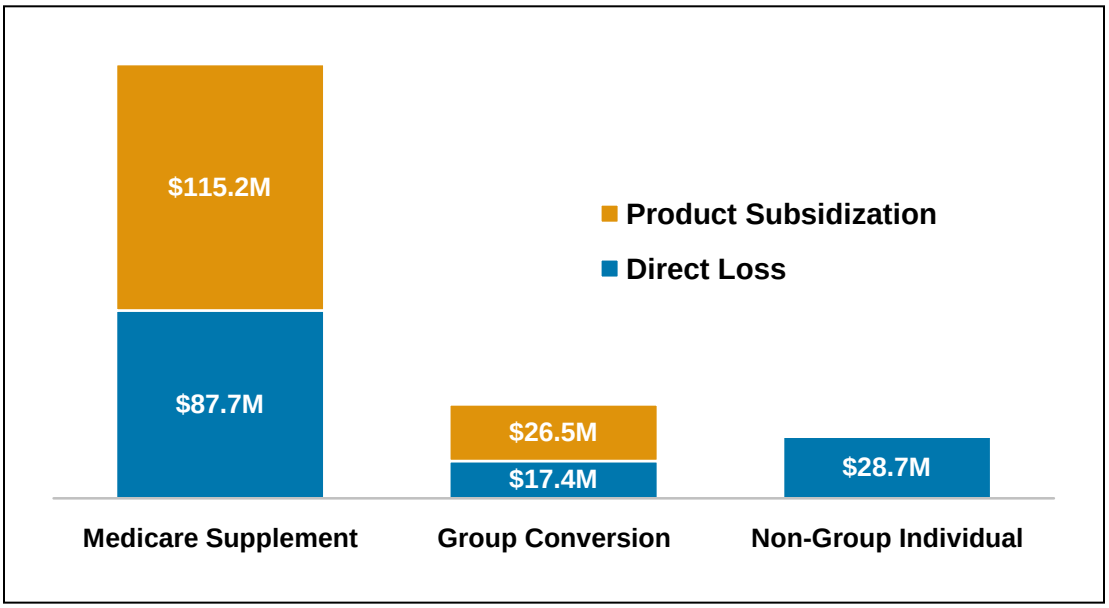
The subsidies BCBSM is required by OFIS to charge both individuals and groups to cover the cost of two individual products (Medicare Supplement and Group Conversion) were $141.7 million[18] and are also included as a social mission activity in this category. Although the subsidies do not directly reflect money taken away from BCBSM's bottom line, using the Pennsylvania framework they should be counted because BCBSM must operate within a market in which other carriers are not obligated to charge the subsidies to subscribers. This gives other insurers a 1% to 2% pricing advantage. To remain competitive, BCBSM has to operate more efficiently to cover this pricing inequity.

Precedent for counting subsidies as a social mission activity has been established in Pennsylvania. All four of the Blues plans operating in that state are using subsidies to offset losses of non-profitable products as one mechanism of meeting the community benefit/social mission requirements set forth in the Community Health Reinvestment Agreement. Additionally, during an interview we conducted in late 2005 with the Michigan Office of Insurance and Financial Services, we learned that OFIS did not object to BCBSM's including the value of the subsidies as a social mission activity.[19]

The final area that should be included in the safety net coverage category is the value of BCBSM's insurer of last resort obligation in Michigan. However, quantifying the expenditures associated with this obligation is difficult. Unlike the mandated subsidies associated with two of the unprofitable individual product lines, there aren't explicit subsidies that are charged to any groups or individuals to offset the costs associated with insuring people who would otherwise be uninsurable.

[17] Amount represents actual value for Jan-Nov 2007 and estimate for Dec 2007, per BCBSM reporting.
[18] Amount represents actual value for Jan-Nov 2007 and estimate for Dec 2007, per BCBSM reporting.
[19] Interview of then-Commissioner Linda Watters and staffer Joan Moiles, December 16, 2005.

Exhibit 2: Illustration of Safety Net Coverage Subsidies [20]



As Exhibit 2 above illustrates, both the Medicare Supplement and Group Conversion products experience significant subsidization, which can be accounted for because the subsidies are directly built into rates. Since the non-group individual product is subject to community rating requirements, it is reasonable to assume there is a group of healthy individuals and groups that are, essentially, subsidizing the costs of insuring the non-healthy individuals. The extent to which this is occurring is difficult to quantify since this subsidy is not specifically built into any rates, and could certainly fluctuate widely between years as the individual subscriber base changes.

It is also reasonable to assume the value associated with being the insurer of last resort extends beyond the direct/indirect subsidies and product losses incurred in any one year. For example, if BCBSM were free to engage in full medical underwriting of individuals or to decline to offer coverage, BCBSM would have less cross-subsidization within any product line and could potentially experience greater product profitability overall. It is also likely that the administrative costs associated with providing coverage for people who would otherwise be medically uninsurable are higher as a result of their utilization of health services. Since administrative costs are allocated across all members, it is difficult to quantify the exact amount by which administrative costs could be lowered if BCBSM did not operate as an insurer of last resort. However, even though the value of forgone profitability is impossible to calculate, it is a real cost the plan incurs as a result of its insurer of last resort obligation.

Another way of framing the insurer of last resort obligation is to consider the benefit health care providers get by delivering less charity care. If BCBSM acted like other insurers and did full medical underwriting—that is, not accept people for coverage due to their health conditions—some people that BCBSM covers today would go uninsured. Those people might pay for some care out of pocket, but a large part of their health care usage would

[20] Amounts do not include December 2007 values.

amount to charity care rendered by providers, or bad debt. BCBSM could be said to be absorbing the costs associated by taking the members that could otherwise not afford coverage, rather than the providers.

The final component of safety net spending is subsidization of hospitals' charity care costs. For 2007, we are crediting BCBSM with having expended $77.6 million[21] toward hospital charity care. In 2006, after negotiations with the Michigan Health and Hospital Association, BCBSM entered into an explicit agreement with all participating Michigan hospitals to help cover their costs of uncompensated care. In 2007, pursuant to the formula set forth in this agreement, BCBSM gave hospitals a total of $130.2 million, comprised of $10.8 million for charity care, $89.0 million for bad debt, and $30.4 million for a "gross-up" meant to cover the forgone operating margin associated with the direct costs of uncompensated care.

We have adjusted the above values as follows:

- $10.8 million for charity care is fully credited.

- We did not accept the full amount of the bad debt coverage allotment, as not all bad debt expense can be attributed to serving the needs of low income patients. According to Bruce McPherson, Executive Director of the Alliance for Advancing Nonprofit Health Care, incorporating some amount of bad debt expenses into social mission calculations is becoming standard practice. Mr. McPherson stated that up to 90 percent of bad debt could be counted as charity care.[22] To be conservative, we have included only 75 percent, or $66.7 million, of BCBSM's actual contribution to hospitals' bad debt expense in 2007.

- None of the $30.4 million in gross-up is credited. Applying a conservative standard, we concluded that while coverage of hospitals' uncompensated care costs is appropriate to include in charity care, covering the margin they lost because those patients were unable to pay is not as compelling.

In summary, BCBSM's total social mission spending in 2007 was at least $391 million. The actual total is likely higher given BCBSM's insurer of last resort status, which we have not quantified because of the inability to specify certain measures. In December 2005, in response to an interview question asking the then-Commissioner of OFIS if the advantages accruing to BCBSM through its state non-profit status are in balance with the regulatory requirements and public expectations of its social mission, Commissioner Linda Watters stated, "Evaluating BCBSM's social mission should also include what it does over and above the net financial effects of its tax savings versus 'social mission' activities."

Benchmarking BCBSM's Overall Social Mission Spending

In this section we compare BCBSM's social mission spending to another similar Blue Cross Blue Shield plan and to the value of the Michigan state and local tax exemption. We also further dissect the $391 million in social mission spending that we can quantify to provide perspective on whether the direction of that spending is meeting the intent of PA 350.

[21] The calculation of charity care and bad debt are rounded such that total uncompensated care equals $77.6M
[22] Interview of Bruce McPherson, January 15, 2008.

Based on the result of these analyses, we believe BCBSM is currently meeting its social mission obligations in terms of the level of spending. Analysis of 2007 social mission outlays shows that BCBSM may, in fact, be surpassing the amount of social mission spending expected under PA 350 by a considerable degree. Additional analysis of year-over-year social mission outlays would need to be conducted to further validate this conclusion.

Comparison of BCBSM Spending to Pennsylvania's Highmark

To further assess BCBSM social mission spending, we compared the BCBSM spending to Highmark, Inc., a large Blue Cross and Blue Shield plan in Pennsylvania. Highmark is a good comparator for BCBSM because it is required to report social mission under the Community Health Reinvestment Agreement and it covers a similar number of people. As mentioned before, Pennsylvania is the only state requiring Blues plans to allocate a fixed percentage of premium dollars to community benefit. According to the agreement, each plan is required to use 1.6% of health premiums and 1.0% of Medicare and Medicaid premiums for community health purposes.

Figures are stated in terms of total plan social mission outlays per state resident. We use a per capita basis, rather than a per plan basis, because arrangements among the Blues plans in Pennsylvania result in the sharing of some members. Additionally, since both BCBSM's and Highmark's social mission activities extend beyond any plan's membership and go instead to the community as a whole, evaluating spending on a per resident basis may be a better way to measure overall commitment to social mission activities.

Exhibit 3: Comparison of Per Capita Social Mission Giving by Highmark and BCBSM

Plan (Year)	Gross Amount of Social Mission Spend	Service Area Total Population (2006)[23]	Giving Per Capita
Highmark (2006)	$243 million	8.5 million	$28.59
BCBSM (2007)	$391 million	10.1 million	$38.68

The analysis demonstrates that BCBSM spends 38 percent more than Highmark on social mission activities. This difference is notable given that the Pennsylvania Blues plans also have enabling legislation that makes them the state's insurers of last resort and they are subject to similar regulatory restrictions as BCBSM. Moreover, unless the Pennsylvania Community Health Reinvestment Agreement is extended, it will end in 2010, potentially freeing the plans in that state of much of their social mission obligation.

Comparison to Michigan's State and Local Tax Exemption

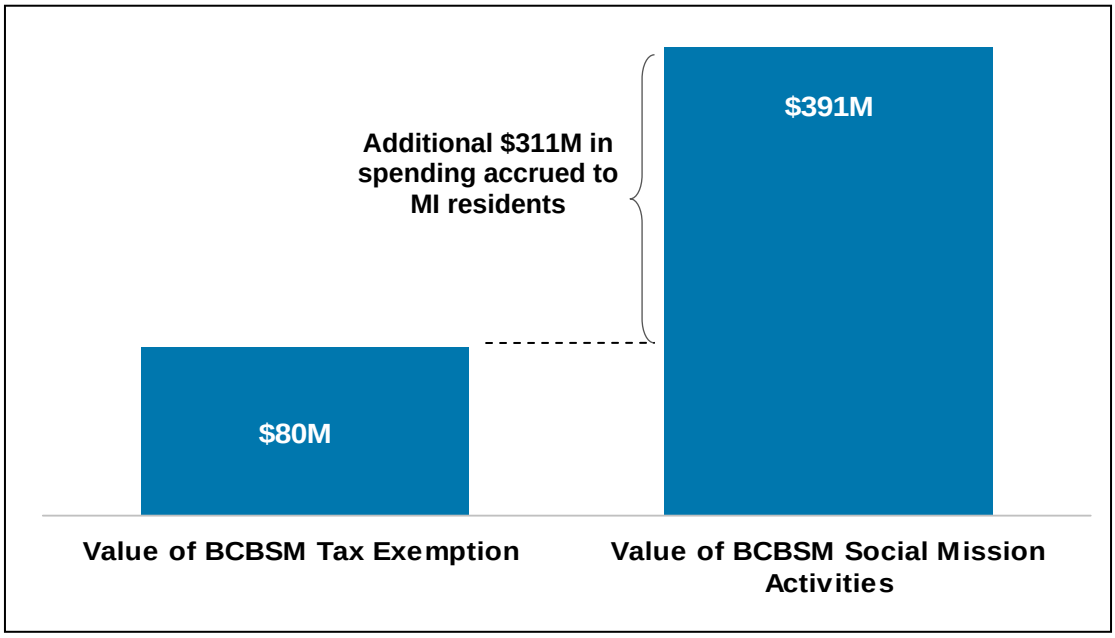
Another way of assessing the level of social mission spending is to compare that spending to the tax exemption given to BCBSM. BCBSM is a non-profit health care corporation and,

[23] Source: U.S. Census, accessed January 19, 2008 at http://quickfacts.census.gov/qfd/. Pennsylvania's total population is 12.4 million. However, Highmark's service area, as a practical matter, excludes the five-county Philadelphia area, which is served by another plan, Independence Blue Cross.

as such, is exempt from state premium taxes and local levies such as property taxes. However, BCBSM is not exempt from federal taxes. An amendment to the Internal Revenue Code in 1986 revoked all the Blues' federal tax-exempt status.

The exhibit below depicts BCBSM's state tax exemption in comparison to its social mission activities. At a premium tax rate of 1.07%, the same rate levied against for-profit plans, and adding in other taxes such as property taxes from which BCBSM is exempt, BCBSM estimates the full value of its state tax exemption to be $80 million in 2007.[24] In comparison to BCBSM's estimated level of social mission funding, Michigan residents gained at least an additional $311 million in community benefit from BCBSM through its voluntary and mandated activities.

Exhibit 4: Comparison of BCBSM's Tax Exemption to Its Social Mission Activities



[24] BCBSM's tax exemption in 2006 was $82M. The estimated 2007 tax exemption is approximately $80M.

Conclusion

The results of this analysis suggest that, in fact, the residents of Michigan actually receive extra benefits as a result of BCBSM's unique status under Michigan law. The extent to which BCBSM's social mission spending is above the value of its state tax exemption is notable. The return to Michigan taxpayers in 2007 from BCBSM's total social mission spending was at least 488 percent—$391 million in social mission spending vs. $80 million in forgone taxes.

It is important to reiterate that this level of return reflects a conservative accounting, as it does not include the full value of BCBSM's insurer of last resort status and is based on the narrowly defined Pennsylvania framework. This analysis, combined with the per resident spending figure above, leads us to conclude that BCBSM is more than meeting its statutory social mission obligations.